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Collective stories and well-being: Using a dialogical narrative approach to understand peer relationships among combat veterans experiencing PTSD

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Abstract

Using a dialogical narrative approach, this original research explored how combat veterans experiencing post-traumatic stress disorder (PTSD) made sense of peer relationships with other veterans, and what effects these relationships had on their well-being. Interviews and participant observations were conducted with 15 male combat veterans (aged 27-60) and one member of the civilian emergency services, the majority of whom were diagnosed with PTSD following traumatic exposure in a range of armed conflicts. All participants were part of a surfing charity for veterans experiencing PTSD. Data were rigorously analysed using a dialogical narrative analysis (DNA). Findings revealed the collective story that veterans used to make sense of peer relationships within the group. This collective story worked for the veterans to shape their experiences of well-being by fostering camaraderie, stimulating deeper connections, and countering the negative effects of PTSD. Potential therapeutic effects of the collective story were also identified. This paper extends previous knowledge on combat veterans and social relationships and advances the field of narrative health psychology through the empirical application of a sophisticated dialogical narrative approach.

Keywords: *Combat veterans; PTSD; social relationships; well-being; narrative*

Peer relationships have been identified as a potential source of support for combat veterans experiencing post-traumatic stress disorder (PTSD) (Hunt & Robbins, 2001; Schok, Kleber & Boeije, 2010). For example, research has indicated that peer support or ‘buddy programs’ can improve health outcomes for veterans in a PTSD treatment context (Greden et al., 2010; Jain, McLean, & Rosen, 2012). Furthermore, research by Schok et al. (2010) has identified the importance of comradeship for veterans struggling to make sense of warzone experiences. Yet despite these initial findings, outside of medical or treatment-focused contexts, little research has explored how veterans make sense of peer relationships in their everyday lives, and how these relationships might contribute to well-being. The purpose of this paper is thus to understand further how combat veterans experience relationships with other veterans, and to explore the possible effects of these relationships for veterans’ psychological health and well-being. This is an important topic given that PTSD is associated with diminished well-being, poorer mental and physical health functioning, and increased risk of suicide (e.g., Jakupcak et al., 2009; Vasterling et al., 2008). Moreover, understanding the potential role of peer relationships in facilitating well-being is timely and relevant given the increasing number of veterans seeking support following recent military involvement in Iraq and Afghanistan (Walker, 2010).

In this paper, we use the term ‘combat veteran’ to refer to *‘any current or former member of the military who has previously deployed to a warzone and been exposed to the risks of combat’* (Caddick & Smith, 2014; p. 16). In addition, PTSD is the term used to describe experiences of psychological and emotional distress (e.g., flashbacks, nightmares, anger, anxiety, sadness, depression and hyperarousal) which some combat veterans experience in the aftermath of traumatic events in war. Research conducted with combat veterans experiencing PTSD indicates that veterans often encounter difficulties in their relationships with others (Hofmann, Litz & Weathers, 2003; Monson, Taft, & Fredman,

2009). In addition, veterans frequently report feeling socially isolated and alienated from society as a result of not only PTSD ‘symptoms’, but also a ‘cultural gap’ between military and civilian worlds (Hofmann et al., 2003; Rahbek-Clemmensen et al., 2012).

Well-being and relationships

The multi-dimensional concept of ‘well-being’ provides a framework for conceptualising possible experiential links between peer relationships and psychological health in combat veterans. The term well-being has been conceptualised in many ways, but it is usefully understood under two broad categories that often overlap or connect in usage: subjective and psychological well-being (Ryan & Deci, 2001). Subjective well-being positions psychological health as maintaining a favourable balance of positive over negative emotions and experiencing satisfaction with one’s life (Diener, 2000). Subjective well-being is often regarded as ‘happiness’ and is also referred to as the ‘hedonic’ school of thought on well-being given its emphasis on experiencing pleasure and avoiding pain (Ryan & Deci, 2001). As Diener (2000) suggested, subjective well-being is intended to reflect a person’s individual evaluation of the quality of his or her life, with ‘quality’ defined by whatever criteria are most meaningful or relevant to that individual.

In contrast, psychological well-being concerns experiences of growth, fulfilment and personal development, rather than happiness *per se* (Ryan & Deci, 2001). Research on psychological well-being has identified six key dimensions thought to constitute optimal psychological health including a sense of self-acceptance, positive relationships with others, a sense of purpose in life, living with a degree of self-determination or autonomy, the ability to manage one’s environment effectively, and feeling that one is growing or progressing towards one’s potential (Keyes, Shmotkin, & Ryff, 2002). The concept of psychological well-being derives from the ‘eudaimonic’ tradition of thought on well-being, which regards

1 ‘flourishing’ and the fulfilment of human potential as constitutive of positive psychological
2 health.

3 *Dialogical narrative approach*

4 A useful way of exploring the possible interconnections between peer relationships and well-
5 being is to adopt a dialogical narrative approach (Frank, 2010; 2012). Drawing on the work
6 of narrative scholar Arthur Frank, a dialogical approach understands people as inherently
7 relational rather than bounded individuals, and storytelling as part of a *dialogue* between two
8 or more voices (Frank, 2005; 2012). As Frank (2005) put it, following the dialogical thoughts
9 of Mikhail Bakhtin, ‘no one person’s voice is ever even his or her *own*; no one existence is
10 ever clearly bounded. Instead, each voice is always permeated with the voices of others’ (p.
11 968; emphasis original). Thus, storytelling is conceived as a *relational* as opposed to an
12 *individual* act, whereby meanings are created through stories in concert with real or imagined
13 others (Smith & Sparkes, 2009).

14 Further emphasising the relationality of storytelling, Frank (2006) argued that stories
15 situate people in groups. Indeed, ‘Stories call individuals into groups, and they call on groups
16 to assert common identities’ (Frank, 2010; p. 60). One way in which this happens is through
17 what Richardson (1990) referred to as ‘collective stories.’ These are shared stories that
18 groups of people tell about experiences they have in common. Collective stories emotionally
19 bind together people who have shared certain experiences, allowing them to overcome some
20 of the isolation and alienation of contemporary life, and linking separate individuals into a
21 shared consciousness (Richardson, 1990). Collective stories thus enable individuals to align
22 their personal identity with that of a group, and to build closer relationships with people with
23 whom they feel some connection. Accordingly, the identification of collective stories offers a
24 practical way of conceptualising a relational or dialogical approach to narrative inquiry.

Another key principle of Frank's (2010; 2012) dialogical narrative approach is that narratives are considered as 'actors' that do things *on, in* and *for* people that make a *difference* to their health and well-being. One way in which narratives act is by shaping our awareness of what psychological health and well-being *is* and *can be* (Caddick, Smith & Phoenix, *in press a*; Smith, 2013). That is, while people may indeed have an embodied intuition of their own well-being as a psychological 'reality', this intuition is constantly being shaped and reshaped by stories that circulate outside us in culture and society (Frank, 2006). Psychological health thus depends partly upon which stories a person chooses to take on board, and what sense is made of those stories (Frank, 2006). Furthermore, the stories a person takes on board will in turn be influenced by their social relationships and the storytelling preferences of the groups or individuals with whom a person chooses to align. In addition, it is worth noting that all stories are, in a sense, *performed* or *enacted*. This is not to suggest that people are always consciously 'performing a story', merely that hearing a story and becoming 'caught up', as Frank (2010) put it, requires *action*.

Study aims and research questions

Set against the above theoretical backdrop, the aim of this study was to understand how a group of combat veterans who belonged to a surfing charity experienced relationships with their peers. Concurrently, the study aimed to understand how telling and enacting relational stories shaped the veterans' experiences of health and well-being in the context of dealing with PTSD. The group of veterans who took part in this research were part of a larger study exploring the effects of surfing in the lives of combat veterans experiencing PTSD (see Caddick, Smith & Phoenix, *in press a*). In this paper, rather focusing on surfing *per se*, the original research questions we sought to address were (a) what story or stories did the veterans use to make sense of their peer relationships? and (b) how did these stories shape the veterans' experiences of subjective and psychological well-being?

Method

As part of the larger study, a purposive sampling strategy was used to recruit participants with a specific knowledge of the topic area and experiences relevant to the research questions. The participants all belonged to a UK-based veterans' surfing charity. The charity works with combat veterans experiencing PTSD, providing weekly 'surf camps' whereby veterans meet together informally to learn and practice surfing. After gaining university ethical approval for the study, members of the charity were contacted individually and asked to participate. The sample included 15 male combat veterans (aged 27-60) who had previously served in a wide range of conflicts, including Northern Ireland, the Falklands, Bosnia, the first Gulf War, and the most recent wars in Iraq and Afghanistan. In addition, one participant was a former member of the civilian emergency services who was diagnosed with PTSD. On hearing of the study, this man also volunteered to take part, bringing the total number of participants to 16.

Further participant characteristics were as follows. At the time of interview, three participants were single, five were married, seven were separated or divorced, and one was widowed. Participants' ages were between 20-30 ($n = 1$), 30-40 ($n = 5$), 40-50 ($n = 6$) and 50-60 ($n = 4$). Time since combat/traumatic exposure ranged from 40 years to less than a year, with the majority of participants experiencing their most severe traumas between 18-22 years ago. In addition, 11 out of the 16 participants had been diagnosed with PTSD. Being officially diagnosed with PTSD was not an inclusion criterion for our study for two main reasons. Firstly, the charity itself did not require a diagnosis as a condition of services. Veterans either self-referred based on their experiences of distress and need for support, or were referred by a mental health professional, family member or social worker prior to diagnosis. Second, the notion of 'PTSD' itself is based on a medicalised understanding of suffering as 'illness' which has been identified in recent years as problematic not only from

an epistemological perspective (e.g., Cromby, Harper, & Reavey, 2013) but also as potentially harmful to the self-concept of people suffering from psychological distress (Tekin, 2011). Regardless of diagnostic status, however, all of the participants utilised the psychological notion of PTSD to describe and explain their suffering.

Data collection

After providing informed consent, all of the participants were involved in semi-structured life history interviews, which were conducted face-to-face between the participant and first author either in the participant's home or at the charity's headquarters. Follow-up interviews were conducted with half of the participants ($n = 8$) when further clarification/elaboration of responses was desired (e.g., when the researchers wished to further explore unanticipated themes that had arisen during the first interview). A total of 24 interviews were conducted, each lasting between 1 and 4 hours. During the interviews, an interview guide (available on request from the first author) was used in a flexible manner to help stimulate reflection on important topics. As the focus of the larger study was on the participants' experiences of both PTSD and surfing, the majority of questions on the guide related to these topics. The semi-structured nature of the interviews then allowed the researcher to seek further reflection/elaboration upon participants' responses that had more to do with social relationships. Examples of elaboration questions included 'what aspects of relationships with other veterans do you feel are important?' and 'how do your relationships with veterans differ from relationships with civilians in your life?' The use of interviews thus had the advantage of enabling the participants to tell detailed, multi-layered stories of how they had lived their lives over time, thereby generating rich storied data.

Alongside the interviews, the method of participant observation (Sparkes & Smith, 2014) was used to help build up a more complex and nuanced account of the participants'

lives and, in particular, their everyday social interactions with the other veterans. Participant observation involved the first author observing the daily activities of the veterans whilst simultaneously taking part in those activities. Particular attention was paid to the social interactions taking place between the veterans across several contexts including: (a) during of the charity's "surf camps" held twice weekly at a local beach; (b) during informal meetings at the charity's HQ (a "drop-in centre" with sofas and tea/coffee where veterans often met together socially), and; (c) during three residential weeks in which the first author was invited to live amongst the group and participate in their activities which included surfing each day, going on coastal walks, and taking part in yoga/meditation sessions. Data were recorded using fieldnotes following a period of observation. Approximately 90 hours of participant observation data were collected. Overall, data collection for this study spanned a period of 1 year and six months, with interviews and participant observations beginning in April 2012 and conducted at routine intervals until September 2013.

Dialogical narrative analysis

All data were recorded, transcribed, and subjected to a dialogical narrative analysis (DNA) which was used to make sense of the observational and interview data in an iterative fashion (Frank, 2010; 2012). DNA examines not only the story told by participants (e.g., a content analysis), but also the work that stories as 'actors' *do* on, in, for, and to people. It thus considers 'the mirroring between what is told in the story - the story's content - and what happens as a result of telling that story - its effects' (Frank, 2010, pp. 71–72). In keeping with the emphasis on relationships and health in this paper, we were interested in the effects of stories both in terms of connecting people into groups (Frank, 2010) and in shaping their experiences of health and well-being (Frank, 2006).

The process of conducting the DNA (see Frank, 2010; 2012) first of all involved the first author immersing himself in the data by reading and closely re-reading the interview transcripts and fieldnotes. Conceptual comments were then made on the transcripts and fieldnotes in order to identify aspects of the data that appeared to speak to the research questions. For example, portions of the transcripts and fieldnotes were selected whereby relationships – and their effects on the veterans – comprised a consistent or recurring theme. *Stories* of varying lengths (e.g., developed across a few lines or several pages of an interview transcript) constituted the primary unit of analysis¹. As part of the unique analytical focus of DNA, the data were then considered in relation to various *dialogical questions* (Frank, 2012) which were asked in order to illuminate the *effects* that stories were having in the veterans' lives. Whilst many dialogical questions were posed in relation to the broader study, specific questions informing this analysis included how stories *connect/affiliate* people into groups, how stories help people create and sustain an *identity*, and what is at *stake* for the teller in a particular story? (Frank, 2012).

Throughout the analysis, theoretical and procedural memos were used to record emerging analytical ideas and interpretations of the data. The analytic process of the DNA also consisted of writing multiple draft reports which were used to develop and test the emerging interpretations. These drafts were read by the second and third authors who acted as 'critical friends' (Sparkes & Smith, 2014), each bringing a different theoretical understanding to the analysis and encouraging reflection upon and alternative explanations of the data.

Findings

The results of the dialogical narrative analysis are presented as follows. The collective story that shaped the veterans' participation in the group is first of all outlined. We then describe the various components of the collective story which helped to shape and define the

relationships between the veterans. Next, we take up the issue of how the collective story affected the veterans' experiences of subjective and psychological well-being, before concluding with some implications of our findings for narrative health psychology.

Collective story: The 'band of brothers'

For the veterans in this study, experiencing distress associated with PTSD led to them feeling isolated – and isolating themselves – from significant others in their lives. Their social world shrank leaving them enclosed and vulnerable to intensified feelings of psychological and emotional distress related to PTSD. However, in stark contrast to the social isolation that characterised their everyday lives, the veterans managed to tell a collective story that emphasised social relationships with other veterans. This story is exemplified by Matthew², a Northern Ireland veteran who described his involvement with the charity as follows:

It's about pulling broken elements of a community together to form a tighter one than the community had in the first place. It's that bond that we've all got that, it just reinforces that you're not on your own and there is that support network – the net that's meant to catch you that you've all fallen through so far – you end up here, and it stops you falling any further. And you kind of make new friends which are slightly bonkers in various ways, but nonetheless – they're still family to me. It's about bolstering each other up and making sure that we're all alright, which I don't think – you know, mainstream societies or communities have got any idea about. It's only that kind of ex-forces – those guys and girls who have done the trigger time and crawled around and bled and got beaten senseless by stuff - that's the bond, and that's what people just recognise instantly, just by kind of – the way they're holding themselves. It's like an impenetrable force-field that once you're inside, you know you're alright. Yeah, that's the kind of binding element to [charity name] - it's that

band of brothers thing - it doesn't matter, like, when you're in the army, you take the piss out the RAF or the Navy or the Marines or whatever, and you still do that here but it really doesn't matter – because if you're walking through that door then you're one of us.

Matthew's comments resonate with Richardson's (1990) description of a 'collective story'; binding the veterans together emotionally and gathering up their individual stories into a shared narrative. The collective story told by the group consists of veterans coming together and supporting each other in dealing with the problems associated with PTSD. The story emphasises a mutual identification with those who share a similar background, and a shared concern for others experiencing the same suffering. The collective story can thus be summarised as follows: *"We have all witnessed terrible events and we all experience PTSD. We are all suffering, but now we are no longer alone. We understand and know each other's suffering and we support each other. We stick together and help each other – just like we did in the forces."* Highlighted also in this story is the intensity of the bonds between veterans, described in terms such as 'family' or a 'band of brothers.' The story thus creates a strong emotional and ethical commitment to support and protect the well-being of other 'family' members in various ways that will be illustrated throughout this paper.

The collective story also does the work of narrative identifying (Frank, 2010); it allows personal identities to form within the collective identity. Similar to processes of military socialisation whereby individual identity is derived from one's place in the organisation (Hockey, 1986), the veterans created and sustained their particular identity as combat veterans through interacting with the group and through enacting the collective story. Furthermore, the collective story is juxtaposed with certain aspects of 'mainstream' societies or communities which are portrayed as unaware of the issues facing veterans and, potentially, unable to offer appropriate support. In this way, the collective story *connects* others who

1 share the status of ‘veteran’ and ‘PTSD sufferer’, and *disconnects* the generalised ‘civilian
2 other’ who lacks the experience of suffering that binds the veterans together.

3 **Dialogical components of the collective story**

4 A number of dialogical components of the collective story shaped how the veterans
5 experienced and made sense of relationships with their peers. These components were
6 dialogical in that they were part of an ongoing dialogue between the veterans that reproduced
7 and reaffirmed the collective story each time the veterans gathered together. As such, the
8 components are not reducible to individual veterans or isolated acts of storytelling. Rather,
9 they emerged *between* the veterans as they mutually and continually acted out the collective
10 story within the group environment. The following dialogical components shaped how the
11 collective story unfolded.

12 *Acceptance and belonging*

13 Feeling part of a collective story fostered a strong sense of acceptance and belonging, which
14 in turn helped to drive forward the collective story. This sense of acceptance and belonging is
15 evident in the following comments by Bob, an army veteran who served in Northern Ireland,
16 who described what happens prior to getting in the water when veterans meet up to go
17 surfing:

18 When we start and we meet up in the car-park, it’s like happy faces straight away and
19 shaking your hand and putting your arm around you, and its just – it’s just brilliant.
20 And you just go into the café and you have a drink and they’re all chatting, and
21 there’s no pressure, and you just feel really comfortable - like you belong there with
22 ‘em.

The veterans in this study all spoke of a sense of acceptance they felt amongst other veterans that was typically absent during interactions with civilian members of their friends and family. Amongst veterans, the psychological suffering associated with PTSD was accepted rather than stigmatised, and was simply recognised rather than questioned or examined. The comments above also indicate how the sense of acceptance was derived not from individual perceptions of 'being accepted', but from embodied actions taking place within relationships (e.g., shaking hands, embracing another by putting one's arm round them). Similarly, the veterans' stories revealed a sense of belonging or a feeling that they were 'at home' in the company of other veterans. Being around other veterans enabled the participants to enact a social 'self' that felt to them more authentic than did relations in civilian life. In part, the collective story thus involved an embodied performance of identity whereby the veterans were able to enact a military identity. For example, the sense of belonging felt by the veterans mirrored the feeling of being part of a close-knit team that they were used to in the military. After seemingly having lost this sense of belonging for good when they left the military, the veterans re-kindled this valued aspect of their identities through interaction with other veterans.

Camaraderie

Another component was camaraderie. This consisted of strong interpersonal bonds between the veterans that mirrored relationships they held with comrades in the military (Green, Emslie, O'Neill, Hunt, & Walker, 2010). For the veterans, these relationships were based on trust, friendship, and mutual rapport. They were often considered deeper than relationships with civilians in their lives. Such bonding with other veterans seemed to satisfy a desire for camaraderie that civilian life had been unable to fulfil. For example, Matthew (quoted above) described how he interacted with other veterans at the charity's HQ:

1 It's that camaraderie again - the thing that you miss the most when you're on de-mob
 2 [de-mobilisation]. And just to walk in here and have...not that we kind of bang on
 3 about why we're all here – we *know* why we're here – but it's just that kind of
 4 building rapports and getting closer, you know. Making better friends each time you
 5 come in. Yeah - in a nutshell.

6 Rather than dwelling on PTSD as the reason for their participation in the group, as the
 7 comments above show, the veterans chose to emphasise the camaraderie that emerged
 8 between them as part of the collective story. Furthermore, camaraderie was developed
 9 through the use of 'black humour.' This was a style of humour - common among members of
 10 the forces (Hockey, 1986) - that the veterans used to make light of their predicament. An
 11 example of this occurred during a residential week on 16th April 2012 and was recorded in
 12 the following fieldnote:

13 This afternoon I was standing on the beach with the guys waiting to go surfing. With
 14 our boards, we formed a half-circle round the instructor who was about to lead us
 15 through some warm-up drills. "Any injuries I should know about?" the instructor
 16 called out before we began. "Yeah", replied one of the guys, "injured minds!",
 17 sending everybody into fits of laughter. Shortly afterwards the guys laughed and
 18 joked their way toward the waters' edge, ready for surfing and in high spirits.

19 As this observation shows, 'black humour' was part of what bonded the veterans and
 20 contributed to the camaraderie they felt with one another. Moreover, many of the veterans
 21 commented in the interviews how much they enjoyed the "slightly twisted" sense of humour
 22 they all shared because it reminded them of better times when they were in the forces.

23 *Not having to explain, yet being understood*

1 The collective story also consisted of a tacit or embodied connection the veterans shared
 2 based on a mutual understanding of combat trauma. This was a connection that did not need
 3 articulating, yet formed a powerful bond between them. Consider, for example, the story told
 4 by Sid - a veteran of the recent war in Afghanistan - about his current circumstances and
 5 about being invited onto a residential week with the charity:

6 I'm sort of in limbo at the moment, not really knowing where my life's going – with a
 7 mountain of shit piling up on top of me. But then you come to somewhere like this
 8 and you're surrounded by people who understand, or care – and then you go surfing to
 9 keep your mind off it, which has been absolutely *brilliant*. I was a bit skeptical to be
 10 honest - about the residential - I didn't think a group of squaddies suffering with
 11 various levels of PTSD in a house together...is this gonna work? But you know, you
 12 don't *have* to sit down and say 'so, tell me about your life.' You just have a mutual
 13 understanding and a respect for each other. You don't *have* to say anything, but you
 14 understand that everyone else understands – and that is a *massive* thing.

15 This tacit, unspoken connection based on mutual understanding and respect for each other's
 16 traumatic experiences was one of the most commonly stated aspects of the collective story
 17 that the veterans told during the interviews. Within the charity, unlike other settings such as
 18 clinical or medical ones, the veterans were not required to explain either their current
 19 problems or their history of trauma. Instead, they felt understood simply by being amongst
 20 other veterans. As Sid continued to explain, "it's not your military history; it's the fact that
 21 you have a history in the military." As such, the data suggest that this dialogical component
 22 of mutual understanding and respect was sustained simply through an *embodied* connection.
 23 The following comments by Eric – a veteran of the first Gulf War and Bosnia - describe the
 24 embodied basis of this connection:

1 I know somebody who's been in combat – spot 'em a mile off. Ask me to explain it
 2 and I can't, it's just something you recognise. I can spot if they've been in the shit,
 3 and relatively, how much they've been in the shit. And it doesn't take them to have
 4 one leg or a blown-off arm, it's the look in their eye. I can recognize it – any veteran
 5 can.

6 For the participants in this study, having other veterans with whom they were able to connect
 7 so effortlessly formed a powerful bond between them, further reinforcing the collective story.
 8 There seemed to be a deeply embodied and tacit form of recognition or communication
 9 among them; something akin to what Shotter (1993) has termed 'knowing of the third kind.'
 10 Following Shotter, this involves the tacit and corporeal levels of understanding and
 11 commonalities of feeling and meaning that allow people to relate to one another (Burkitt,
 12 1999). It constitutes a 'knowing from within' that occurs during specific interactions between
 13 embodied actors (e.g., between veterans as they surf together on a residential week). For the
 14 veterans in this study, this translated into an instinctual knowledge that they seemed to share
 15 regarding each other's problems.

16 *Looking out for each other*

17 Part of the collective story emphasised a mutual expectation that support would be offered to
 18 those who needed it. This did not mean simply that support was *available* for those who
 19 wished to take advantage of it, but that group members would *actively* offer and provide
 20 support to those who appeared to be struggling. As Samuel, a former member of the Navy
 21 who saw active service in Northern Ireland, said:

22 I don't think there's any expectations that people are gonna be alright, or that
 23 someone should be dealing with this in a certain way, or you should be able to cope
 24 with things. You know, if someone's not coping with something, it's like 'well,

1 alright, you're not coping with it, give 'em a hand.' I don't know whether that's a
 2 healthy thing, but I think that's what we've always done - when we were in whatever
 3 service we were in, you had people around you that you knew were there, you didn't
 4 have to arrange for them to be there, they were just there...and that kinda happens
 5 here naturally.

6 In his study of 'squaddie' subculture, Hockey (1986) identified the overriding concern of
 7 serving soldiers as 'looking out for their mates.' The above comments show this concern
 8 being reproduced as a key feature of the collective story. The veterans often described a sense
 9 of being there for others and supporting them in their efforts at dealing with PTSD. Likewise,
 10 the necessity of 'looking out for each other' sometimes called upon veterans to take certain
 11 actions to help safeguard the well-being of others. Consider the following fieldnote recorded
 12 on 17th August 2012 following one of the charity's weekly surf camps.

13 On the way back from the beach, I joined the group leader (also a veteran) as he
 14 stopped by the home of one guys to check up on him. This veteran had gone 'under
 15 the radar'. This means he is not answering his phone and no-one has seen him for a
 16 while. Waiting at his door, I asked the group leader "Is this what you do when
 17 someone goes under the radar?"... "It's what we have to do", he replied, "We have to
 18 do this to make sure they're ok."

19 *Normalising and legitimising suffering*

20 The veterans frequently articulated their previously held views that they were both alone in
 21 suffering distressing feelings, and that their distress was a sign of weakness. Indeed, as the
 22 veterans themselves pointed out, they had been part of a military culture in which the notion
 23 of emotional distress as 'weakness' was deeply embedded (Green et al., 2010). As a result of
 24 their complicity within this cultural system, many of the veterans had for a long time resisted

the notion that there was ‘something the matter’ and refused to seek help. However, when the veterans eventually did reach out (or were forced to by their partners), they were able to re-interpret their suffering through the lens of the collective story. As Sid (quoted above) suggested:

Coming here made me realise that I’m not the only one. That’s the biggest thing, realising that you’re not the only one, and asking for help isn’t frowned upon – they’re the two biggest shockers. I was almost in tears when I realised I wasn’t the only asshole in the same situation with those feelings. It tore me up inside – which made me realise that there’s an awful lot of people out there that need help. When they realise they’re not alone, everything changes [clicks fingers], almost instantly. And its gut-wrenching when it happens because you realise what a sad fool you’ve been to yourself.

Being surrounded by other veterans who shared the collective story enabled the participants to understand that they were not simply “going crazy” as many of them had previously anticipated. In other words, it helped to *normalise* the experience of psychological and emotional distress and reassured them that it was ‘ok’ to suffer distress as they did. Furthermore, it reassured them that seeking help did not have to damage their social identity as ‘strong and resilient’ ex-soldiers. That is, being around other veterans who were not afraid to ask for support helped *legitimate* the process of help seeking and allowed the veterans to reach out for support without damaging their self-concept and masculine identity (see Caddick, Smith & Phoenix, *in press b*).

Well-being and the collective story

The collective story had a number of implications for the veterans’ experiences of subjective and psychological well-being. Firstly, the story acted *for* the veterans to bolster their

subjective well-being. By fostering camaraderie with other veterans, the participants in this study experienced a renewed sense of pleasure in life that contrasted markedly with their day-to-day suffering and countered the negative effects of PTSD. For example, laughter was seen as ‘good medicine’ for the veterans’ feelings of anguish and despair, helping to lift their well-being as the following comments from Lewis, a veteran of the Iraq war, demonstrate:

It [camaraderie] takes the concentration off meself and stops me feeling sorry for meself...I think it’s important to have a laugh and enjoy yourself because if you don’t then the depression’s gonna beat you. But with everyone mucking around having a laugh, the depression ain’t gonna get anywhere.

By enacting the collective story and experiencing camaraderie, the veterans were able to boost their well-being through what Simmel (1971) termed sociability; that is, interacting sociably for the pleasure of interaction itself. Moreover, such pleasurable interactions were enabled by the sense of belonging and connection the veterans felt toward other members of the group. Outside the group, the veterans felt they could not interact with civilians in quite the same way, thereby reinforcing the importance of other veterans for bolstering subjective well-being through camaraderie and sociable interaction.

Second, the collective story helped the veterans to cultivate psychological well-being by drawing them together as part of a close-knit ‘family.’ Through each of the dialogical components of the collective story, the veterans developed strong interpersonal relationships with each other, which helped nurture feelings of psychological well-being. In particular, the tacit and embodied connection fostered by the sense of *not having to explain, yet being understood* enabled the veterans to experience a deeper connection to others; something which forms a key element of psychological well-being (Ryff & Singer, 1998). Furthermore, the ethical ideal of a robust social support network created by the mutual obligation to ‘look

out for each other' helped protect the veterans' well-being from the problems of suffering and isolation related to PTSD. As Eric suggested, "If it wasn't for [charity] and the people that I know from there, I don't know how well I'd get on to tell you the truth, because they are just – *dependable*."

Third, and linked with the above points, the collective story helped define what was *at stake* for the veterans in telling and enacting their shared narrative (Frank, 2012). That is, in Frank's (2012) terms, the collective story helped the veterans understand how to '*hold their own*' against PTSD. By 'holding one's own', Frank means 'seeking to sustain the value of one's self or identity in response to whatever threatens to diminish that self or identity' (p. 33). Holding one's own by way of a story involves first of all hearing that story and then allowing it to shape one's actions in accordance with the values it proposes. For the veterans, the collective story identified close relationships with other veterans as particularly valuable and constitutive of well-being. Connecting with others thus became an important priority for the veterans in terms of drawing support for their own well-being whilst simultaneously providing support for other members of the group. As such, the story offered the veterans a compelling means of collectively holding their own against the suffering and despair of PTSD.

Discussion

In this paper, we utilised a dialogical narrative approach to highlight veterans' experiences of peer relationships and the effects of these relationships on their subjective and psychological well-being. In response to our research questions, our findings identified a 'collective story' (Richardson, 1990) which the veterans utilised to make sense of their peer relationships, alongside five dialogical components of the collective story which acted *for* the veterans to shape their experiences of well-being. These dialogical components included *acceptance and*

1 *belonging; camaraderie; not having to explain, yet being understood; looking out for each*
 2 *other, and; normalising and legitimising suffering.* Moreover, the collective story and its five
 3 dialogical components shaped the veterans' experiences of subjective and psychological well-
 4 being by facilitating deeper connections with others, emphasising positive sociable
 5 interactions and camaraderie, and by creating a robust network of mutual support; all of
 6 which helped the veterans to 'hold their own' against PTSD.

7 This paper contains a number of implications for the field of narrative health
 8 psychology and for research on PTSD, social relationships, and combat veterans in particular.
 9 Firstly, the paper advances the field of narrative health psychology through the empirical
 10 application of a sophisticated dialogical narrative approach. This approach uniquely
 11 demonstrates that a person's story is never his or her *own* in a possessive, individualist sense
 12 (Frank, 2005). Rather, following Frank (2005) and Bakhtin (1984), individual stories are
 13 formed in an ongoing process of anticipation and response to others' stories (whether this
 14 anticipation and response takes place in inner dialogue or external talk). For example, we
 15 showed that veterans' individual stories are formed only in relation to the collective story of
 16 veterans supporting veterans as they deal with PTSD. Telling this story required veterans to
 17 listen and respond to the stories of others as they interacted with each other in the group
 18 environment. Such responses also took the form of *actions*, as the veterans acted out elements
 19 of the collective story in response to the prior actions of another - and so the story continues.
 20 Narratives of health and illness might thus be fruitfully acknowledged as dialogical and
 21 responsive to others; those others' responses also having the power to act *on* and *for* us and to
 22 shape what we know as health (Smith & Sparkes, 2011; Frank, 2006).

23 Second, the research contributes to knowledge on veterans and social relationships by
 24 highlighting not only the benefits to well-being, but also the possible *dangers* or relational
 25 *tensions* that were created by the collective story. In addition to working *for* the veterans by

1 connecting them with each other, the collective story also had the potential to work *on* them
2 in one respect. That is, the story could also *disconnect* the veterans from the ‘civilian other’
3 who was placed outside the story. For example, the veterans’ collective story often
4 emphasised a boundary between “us” and “them”; with veterans on the one side who
5 understood each other’s problems and were able to empathise - who “got it” - and civilians on
6 the other side who “just didn’t get it.” This is understandable, given that civilians have not
7 shared the experiences of combat trauma that veterans have been through. However, rather
8 than seeking to reconcile or overcome the differences between veterans and civilians, the
9 collective story appeared to highlight these differences as a further source of connection
10 between the veterans. As a result, social relations and possibilities for dialogue and
11 understanding between veterans and civilians (including, for example, family, friends, and
12 healthcare professionals) were closed off.

13 Third, this research extends current knowledge on treating veterans experiencing
14 PTSD by identifying potential ‘therapeutic’ effects of the collective story on the veterans’
15 lives. Our use of the word ‘therapeutic’ does not indicate an alignment with clinical or
16 medical model approaches to the treatment of distress. Rather, in addition to the effects on
17 well-being outlined above, this term is used to denote a possible healing effect on the
18 veterans’ lives in the context of their experiences of PTSD. These therapeutic healing effects
19 may primarily be conceptualised in terms of Smail’s (2001) ingredients of ‘therapy.’ Smail’s
20 critical take on psychotherapy suggests that the majority of approaches to therapy have at
21 their core the same three ‘ingredients’ of comfort, clarification, and encouragement/support.
22 It is these three non-technical, basically personal, aspects of the therapist-client relationship
23 that Smail suggests can help people in distress, rather than any ‘cognitive readjustments’ or
24 other manipulations that a therapist might perform. Moreover, the three ‘ingredients’ are not

specific to psychotherapeutic encounters, and indeed were present among the veterans in this study, embedded in the collective story.

For example, the veterans derived a sense of *comfort* from the dialogical components of ‘acceptance and belonging’ and ‘not having to explain yet being understood.’ As Smail (2001) suggested, comfort may be achieved through ‘acknowledgement of our condition and affirmation of our experience’ (p. 170). For the veterans in this study, being accepted and welcomed into a new ‘family’ of combat veterans provided such affirmation and helped to relieve the pervasive social isolation in their lives. Furthermore, being understood without needing to explain their predicament brought about a comforting sense of relief for the veterans. For several participants, this comforting feeling of relief was even more pronounced given their previous frustrations at trying without success to explain themselves to civilian doctors and therapists. In addition, *clarification* involved de-mystifying the reasons for, or ‘causes’ of, the veterans’ psychological and emotional distress (Smail, 2001). For the veterans, the normalisation and legitimisation of their distress was also a clarification that their suffering was not ‘caused’ by personal weakness, but was instead a reasonable reaction to the traumatic events they had encountered in combat. Clarification also took place when veterans realised that their suffering was not a bizarre or abnormal reaction to trauma and that others too were suffering just as they were.

Furthermore, the veterans benefited from being *encouraged and supported* by others to cultivate personal and social resources to help deal with or confront their problems (Smail, 2001). Several resources aligned with the multidimensional concept of social support (Cutrona & Russell, 1990) were cultivated through the collective story in which the veterans were caught up. For example, the availability of *emotional support* through camaraderie and through identification with the collective story ensured that the veterans did not have to ‘suffer in silence.’ It also provided them with a source of solidarity especially during times of

intense stress or desperation. Similarly, the dialogical component of ‘looking out for each other’ included a wide potential range of supportive actions. For instance, looking out for another veteran could at times involve *tangible* support such as offering a hot meal and a bed to someone who needed a place to stay. At other times, it could involve *informational* support in terms of advice on how to deal with certain PTSD ‘symptoms.’ As such, our research shows that peer relationships not only influence well-being among veterans, they may also be important from a ‘therapeutic’ perspective, as explicated by Smail (2001). Indeed, whilst veterans are unlikely to enter into peer relationships for the purpose of ‘therapy’, the above therapeutic effects may be an important by-product of these relationships that mimic certain aspects of a traditional therapist-client relationship.

There are further practical implications of our findings for narrative health psychology. One implication is that collective stories may be viewed as a form of *narrative care* (Bohlmeijer, Kenyon, & Randall, 2011; Ubels, 2011). Narrative care involves the empathic use of stories in healthcare settings. As Frank (2007) argued, stories themselves have the capacity to *take care* of people, for example by affirming what is valuable and by sharing one’s pain and suffering with others. The collective story may be taking good care of the veterans by affirming the value of peer relationships for health and by making the support of others readily available. Moreover, the story may help care for veterans by helping them overcome the widely reported influence of stigma in preventing veterans experiencing PTSD from seeking support for their health and well-being (Walker, 2010). Indeed, by normalising and legitimising their suffering, collective stories such as the ‘band of brothers’ narrative could help foster solidarity among groups of combat veterans, reduce stigma, and increase the availability of support.

Collective stories as narrative care might thus be recognised and supported in PTSD treatment settings. One practical way of encouraging collective stories may be for providers

1 of support and treatment to create a context in which veterans can interact informally with
2 one another. Such informal interactions may enable veterans to share their stories, form
3 bonds with each other, and to draw therapeutic benefits from relationships with other
4 veterans. As such, rather than focusing solely on treating individual veterans' PTSD
5 'symptoms' (as clinical or medical approaches are often inclined to do), support for combat
6 veterans might place a greater emphasis on relationships between veterans as part of the
7 treatment process.

8 One issue we were unable to take up in this study is *how* veterans become, as Frank
9 (2010) put it, 'caught up' in a collective story in the first place. That is, how are collective
10 stories communicated and shared between people so that others can hear and become part of
11 the story if they so choose? This question has wide potential implications because in order for
12 a story to affect someone, that story first needs to be heard and taken seriously as worth
13 listening to and acting on. Understanding how the communication of collective stories takes
14 place may be a fruitful topic for future exploration. In addition, part of this work could
15 include efforts to integrate civilians (e.g., veterans' family and friends) into veterans' lives
16 and ways of understanding things, perhaps through engaging more deeply with veterans'
17 stories. As Frank (2010) suggested 'stories have the capacity to make one particular
18 perspective not only plausible but compelling' (p. 31). Through listening and responding to
19 veterans' stories (such as the ones presented in this article) and the perspectives these stories
20 articulate, possibilities for dialogue, understanding, and well-being not only among veterans,
21 but also between veterans and civilians may be enhanced.

22 Notes

23 1. For a detailed discussion of what constitutes a story in narrative analysis, see Frank (2010,
24 2012)

1 2. All names are pseudonyms

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9 **References**

- 10 Bakhtin, M. (1984). *Problems of Dostoevsky's poetics* (C. Emerson, Ed. & Trans.).
11 Minneapolis: University of Minnesota Press.
- 12 Bohlmeijer, E., Kenyon, G., & Randall, W. (2011). Toward a narrative turn in healthcare. In
13 G. Kenyon, E. Bohlmeijer, & W. Randall (Eds.), *Storying later life* (pp. 366-380).
14 New York: Oxford University Press.
- 15 Burkitt, I. (1999). *Bodies of thought: Embodiment, identity and modernity*. Thousand Oaks,
16 CA: Sage.
- 17 Caddick, N., & Smith, B. (2014). The impact of sport and physical activity on the well-being
18 of combat veterans: A systematic review. *Psychology of Sport and Exercise*, 15, 9-18.
- 19 Caddick, N., Smith, B., & Phoenix, C. (*in press a*). The effects of surfing and the natural
20 environment on the well-being of combat veterans. *Qualitative Health Research*.
- 21 Caddick, N., Smith, B., & Phoenix, C. (*in press b*). Male combat veterans' narratives of
22 PTSD, masculinity, and health. *Sociology of Health and Illness*.
- 23 Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*.
24 Basingstoke: Palgrave Macmillan.

- 1 Cutrona, C., & Russell, D. (1990). Types of social support and specific stress: Toward a
2 theory of optimal matching. In B. Sarason, I. Sarason, & G. Pierce (Eds.), *Social*
3 *support: An interactional view* (pp. 319-366). New York: Wiley.
- 4 Diener, E. (2000). Subjective well-being: the science of happiness and a proposal for a
5 national index. *American Psychologist*, 55, 34-43.
- 6 Frank, A. W. (2005). What is dialogical research, and why should we do it? *Qualitative*
7 *Health Research*, 15, 964-974.
- 8 Frank, A. W. (2006). Health stories as connectors and subjectifiers. *Health: An*
9 *Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 10,
10 421-440.
- 11 Frank, A. W. (2007). Five dramas of illness. *Perspectives in Biology and Medicine*, 50, 379-
12 394.
- 13 Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago: University of
14 Chicago Press.
- 15 Frank, A. W. (2012). Practicing dialogical narrative analysis. In J. Holstein & J. Gubrium
16 (Eds.), *Varieties of narrative analysis* (pp. 33-52). London, UK: Sage.
- 17 Greden, J., Valenstein, M., Spinner, J., Blow, A., Gorman, L., Dalack, G., Marcus, S., &
18 Kees, M. (2010). Buddy-to-Buddy, a citizen soldier peer support program to
19 counteract stigma, PTSD, depression, and suicide. *Annals of the New York Academy*
20 *of Sciences*, 1208, 90-97.
- 21 Green, G., Emslie, C., O'Neill, D., Hunt, K., & Walker, S. (2010). Exploring the ambiguities
22 of masculinity in accounts of emotional distress in the military among young ex-
23 servicemen. *Social Science and Medicine*, 71, 1480-1488.
- 24 Hockey, J. (1986). *Squaddies: Portrait of a subculture*. Exeter: University of Exeter.

- 1 Hofmann, S., Litz, B., Weathers, F. (2003). Social anxiety, depression, and PTSD in Vietnam
2 veterans. *Anxiety Disorders*, 17, 573–582.
- 3 Hunt, N., & Robbins, I. (2001). World War II veterans, social support, and veterans'
4 associations. *Aging & Mental Health*, 5, 175-182.
- 5 Jakupcak, M., Cook, J., Imel, Z., Fontana, A., Rosenheck, R., & McFall, M. (2009).
6 Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and
7 Afghanistan war veterans. *Journal of Traumatic Stress*, 22, 303-306.
- 8 Jain, S., McLean, C., Rosen, C. (2012). Is there a role for peer support delivered interventions
9 in the treatment of veterans with post-traumatic stress disorder? *Military Medicine*,
10 177, 481-483.
- 11 Keyes, C., Shmotkin, D., & Ryff, C. (2002). Optimizing well-being: The empirical encounter
12 of two traditions. *Journal of Personality and Social Psychology*, 82, 1007-1022.
- 13 Monson, C., Taft, C., & Fredman, S. (2009). Military-related PTSD and intimate
14 relationships: From description to theory-driven research and intervention
15 development. *Clinical Psychology Review*, 29, 707–714.
- 16 Rahbek-Clemmensen, J., Archer, E., Barr, J., Belkin, A., Guerrero, M., Hall, C., & Swain, K.
17 (2012). Conceptualizing the civil–military gap: A research note. *Armed Forces &*
18 *Society*, 38, 669-678.
- 19 Richardson, L. (1990). *Writing strategies*. London: Sage.
- 20 Ryan, R., & Deci, E. (2001). On human happiness and potentials: a review of research on
21 hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52, 141-166.
- 22 Ryff, C., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry*,
23 9, 1-28.

- 1 Schok, M., Kleber, R., & Boeije, H. (2010). Men with a mission: Veterans' meanings of
2 peacekeeping in Cambodia. *Journal of Loss and Trauma, 15*, 279-303.
- 3 Shotter, J. (1993). *Conversational realities: Constructing life through language*. London:
4 Sage.
- 5 Simmel, G. (1971) *On Individuality and Social Forms: Selected Writings*, ed. D.N. Levine.
6 Chicago, IL: University of Chicago Press.
- 7 Smail, D. (2001). *The nature of unhappiness*. London: Robinson.
- 8 Smith, B. (2013). Disability, sport and men's narratives of health: A qualitative study. *Health*
9 *Psychology, 32*, 110-119.
- 10 Smith, B., & Sparkes, A. C. (2009). Narrative inquiry in sport and exercise psychology: What
11 can it mean, and why might we do it? *Psychology of Sport and Exercise, 10*, 1-11.
- 12 Smith, B., & Sparkes, A. (2011). Exploring multiple responses to a chaos narrative. *Health:*
13 *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 15*,
14 38-53.
- 15 Sparkes, A. C., & Smith, B. (2014). *Qualitative research methods in sport, exercise & health.*
16 *From process to product*. London: Routledge.
- 17 Tekin, S. (2011). Self-concept through the diagnostic looking glass: Narratives and mental
18 disorder. *Philosophical Psychology, 24*, 357-380.
- 19 Ubels, G. (2011). Implementation of narrative care in the Netherlands: Coordinating
20 management, institutional, and personal narratives. In G. Kenyon, E. Bohlmeijer, &
21 W. Randall (Eds.), *Storying later life* (pp. 319-337). New York: Oxford University
22 Press.

- 1 Vasterling, J., Schumm, J., Proctor, S., Gentry, E., King, D., & King, L. (2008).
2 Posttraumatic stress disorder and health functioning in a non-treatment-seeking
3 sample of Iraq war veterans: A prospective analysis. *Journal of Rehabilitation*
4 *Research & Development*, 45, 347-358.
- 5 Walker, S. (2010). Assessing the mental health consequences of military combat in Iraq and
6 Afghanistan: A literature review. *Journal of Psychiatric and Mental Health Nursing*,
7 17, 790-796.